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ABSTRACT

Nine papers review procedures used by Head Start programs to solicit and coordinate community resources. The first article describes a seven step approach to using resources in a rural area, while the second paper identifies types of available specialists and suggests where they can be located. Suggestions of other programs for enlisting the help of specialists are given. The services of publicly funded agencies are considered, and guidelines are set forth for training Head Start personnel to use specialists. In addition to a glossary of specialist terms, methods are described for initial meetings with specialists to request services. The use of community resources in Indiana County Head Start, Inc., is summarized. The document concludes with the executive summary of the American Academy of Pediatrics on screening diagnosis and assessment of handicapped children in Head Start. (CL)

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COMPREHENSIVE DEVELOPMENTAL TEAM BOOKLET SERIES

SPRING, 1977

UTILIZATION OF COMMUNITY RESOURCES

HEAD START RESOURCE AND TRAINING CENTER

Mental Health/Services to Handicapped Component

Conferences and Institutes Division

University of Maryland University College

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Most of the information presented in this booklet has been adapted from the Minnesota OCD-BEH Collaboration Project in St. Paul, Minnesota. The model, developed in St. Paul, has been adapted by the HSRTC in the development of the Comprehensive Developmental Team (CDT). This booklet is developed specifically for use by local Head Start programs as they implement Comprehensive Developmental Teams.

Other Head Start and day care programs may find the information contained here helpful in soliciting the services of resource specialists.

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UTILIZING RESOURCES TO MEET THE SPECIAL NEEDS OF CHILDREN

by Shirley Bateman and Margaret Hallau

Every child is a unique individual with particular strengths and weaknesses. Each has an individual rate of development and style of learning. The job of the staff of a Head Start program is to determine each child's abilities and create the best possible learning situation for the child. Some children may have needs which the teacher cannot meet or problems she cannot solve. The teacher must then have available the means for utilizing a professional person who has the training and experience to assess the problem and suggest the kinds of teaching techniques which will lead to success for the child. Following is a system by which teachers, professionals with special expertise, and other services can work together for the child's benefit.

STEP ONE: DETERMINE WHO IN THE HEAD START PROGRAM WILL HAVE PRIMARY RESPONSIBILITY FOR LOCATING SPECIALISTS, SECURING THEIR COOPERATION, AND ESTABLISHING A DIAGNOSTIC TEAM.

One person in the Head Start program should be delegated the responsibility for contacting and coordinating the efforts of the diagnostic team. Services can then be located before the need arises and duplication can be prevented. This person is usually the local coordinator of services to the handicapped, although some programs may use the social services, health, or education coordinator or possibly the director.

STEP TWO: DETERMINE THE KINDS OF SPECIALISTS NEEDED.

Basic to every program should be a diagnostic team of professionals including the following: a medical doctor; an ear, nose, and throat specialist; an audiologist; a speech clinician; a psychologist; an orthopedist; an opthalmologist; and a neurologist. Some of the team members, like the audiologist and medical doctor, will be used frequently. However, to facilitate the delivery of services these specialists also need to be contacted before the need arises.

STEP THREE: LOCATE POSSIBLE RESOURCES

Programs located in an urban area will probably find many agencies and professionals with special expertise who provide the same service. In fact, several agencies may be struggling to locate and serve the same children. The task of the coordinator is to determine who provides the best service at the most reasonable cost.

Programs located in rural areas have a different set of problems. Such programs may find that needed team members are not available locally. The coordinator's job is more difficult in that she must locate agencies or individuals responsible for serving a particular geographic area. In addition, she must consider the problem of transportation. The coordinator

will always have available to her at least three resources which will assist her in locating team members: Public Health Departments, Dividion of Family Services, and Bureau or Department of Special Education located in the State Department of Education. The Public Health Department and Division of Family Services can provide information about agencies or professionals who serve and area as well as the name of a contact person. The Department of Special Education, on the other hand, can provide information about resources available in special areas.

STEP FOUR: CONTACT POSSIBLE RESOURCES

In order to utilize resources effectively, the coordinator must set up a systematic approach for contacting the potential resources she has located and then organize the information received from the contact. One approach is to prepare resource cards which will be filled in as she contacts each agency. These cards help her state clearly the information she needs as well as providing a convenient means of recording and organizing information. Each card includes the following information:

Area:_____

Agency:_____ Telephone:_____

Address:_____ Zip:_____

Contact Person:_____Title:_____

Services:_____

Costs:_____

Restrictions:_____

Method of Referral:_____

Time:_____

Follow-up Notes:_____ _____

_____

How we can help this agency:_____

It should be noted that often a coordinator will need to call several people in an agency before the appropriate person is located. After the cards are completed, they may be filed alphabetically under the handicapping condition or the service provided.

STEP FIVE: COORDINATE DELIVERY OF SERVICES TO THE CHILD

Each Head Start program should establish a local Head Start staffing team including teachers and coordinators of education, health, social services, and handicapped. This staffing team reviews the progress made by each child in various areas. In some cases, the staffing team may recommend that a child be referred for further testing or services since the Head Start program is not able to meet all of the child's needs. The local coordinator of services to the handicapped checks her resource file to locate the appropriate agency or professional. She makes the referral and informs the staff and parents of the scheduled appointment with the agency. Sometimes, the professional will come to the center. In this case, the coordinator will need to make arrangements at the center for a quiet spot and anything else the specialist might have requested. Most of the time, however, the child will need to be transported to the agency. An aide or volunteer may take the child and parent to the agency, or the parent may prefer to take the child himself.

In many cases the child and his family require services in addition to further assessment. The coordinator of services to the handicapped, in conjunction with the social services coordinator, will help the family tap into all the resources, such as Aid to Dependent Children, which are available in a community.

STEP SIX: MODIFY THE CHILD'S PROGRAM AFTER RECEIVING RESULTS FROM ADDITIONAL ASSESSMENTS.

The results from additional assessments are used to help plan a more appropriate program for the child, to identify the needs of the child and his family which may require additional services, and to identify training needs of the staff. If at all possible, the various professionals who participated in the assessment of the child should meet with the Head Start staffing team to determine the prescriptive program for the child. Since such a meeting is not usually feasible in a rural area, the coordinator of services to the handicapped will present the reports and evaluations during a meeting of the Head Start staffing team. The team will then develop a program for the child.

Utilizing input from the staff members working with the child, the coordinator of services to the handicapped can determine areas in which the staff needs additional training. She is responsible for either providing the training or for arranging for someone to provide training. In some cases, the agency who has participated in the assessment of the child can provide staff training. The coordinator may also contact other agencies in her resource file, since she made note of those who could provide training when she made the initial contact. In addition, the Outreach center may be able to make additional suggestions.

STEP SEVEN: REEVALUATE THE CHILD'S PROGRESS PERIODICALLY

The ongoing records which are usually kept of a child's progress should be reviewed by the staffing team periodically to determine whether the child is progressing and whether additional services need to be provided. In some cases, additional assessment may be recommended while in other cases the child will be making satisfactory progress and his family will be utilizing appropriate community resources.

"BUT HOW CAN OUR PROGRAM PROVIDE SPECIALIST SERVICES?"

Head Start and many other preschool programs lack the financial resources to hire their own clinical specialists such as psychologists, speech pathologists, and special education teachers, etc. Even with a substantial budget it would be almost impossible for one operation to hire the wide variety of necessary specialists needed to work with different types of special needs children. However, programs can obtain specialist services for children, families and staff by mobilizing resources already in the community. In many communities several specialists are employed by public funded agencies which are required to serve populations like Head Start and preschool programs.

"WHAT KINDS OF AVAILABLE SPECIALISTS CAN BE HELPFUL IN ASSISTING STAFF AND FAMILIES IN MY PROGRAM? WHERE CAN THEY BE LOCATED?"

- the public health nurse - this person can be particularly helpful for several reasons. The public health nurse often is somewhat of a generalist with professional skills in medical health and immunization, preventive community health, infant care and development, family assistance, professional referral and some background in early childhood development. This specialist is often accustomed to extending her/his services to a wide variety of people and community organizations like Head Start. Public health nurses are often employed by city or county welfare, public health, social service and family service departments. They also work in mental health centers, hospitals, universities and colleges, and special clinics. Although often not a "public health nurse" per se, some school nurses are also available for assistance.

- the child psychologist - in the area of child behavioral development, this is often the specialist with the broadest expertise. Though a child psychologist will often specialize in a particular subject, most have some background in child development of personality, social/emotional, cognitive, perceptual, motor, and language skills. As a broad-based specialist in child development, this person can offer services of observation and diagnosis, treatment of some behavioral difficulties, counseling to parents, and consulting to teachers. Most of the available child psychologists are employed by public school systems and mental health centers. Others are employed in hospitals, universities and colleges, special clinics and private practice.

- the speech pathologist - this clinician is a specialist in the development and correction of all aspects of verbal communication including articulation, language comprehension and expression, voice, motor skills of speech, hearing and auditory perception. Some speech clinicians are also involved in some aspects of other communication techniques such as reading and writing. The speech pathologist can offer services of screening, informal observation, diagnosis, treatment and family and teacher counseling. Most speech pathologists are employed in the public schools. Others are located in mental health centers, hospitals, universities and colleges, special clinics, and private practice.

- the social worker - this worker can be particularly helpful in working with families of special needs children. Some social workers also will counsel teachers and aid with observation of particular children and classrooms. This person often is a local authority of available resources in health, education and welfare. Social workers are often employed in the same settings mentioned above for public health nurses.

- the special education teacher - The special education teacher often works with special needs youngsters in a classroom group setting, making the experiences of this person particularly important to the preschool staff. This person might also be known as a specialist in learning disabilities (LD), special learning and behavior problems (SLBP), special learning disabilities (SLD), etc. Some of these teachers specialize in working with youngsters who are educable mentally retarded (EMR) or trainable mentally retarded (TMR). This specialist has some professional exposure to a wide range of developmental disabilities including visual-motor-perceptual skills. Most special education personnel are employed in the public schools, although universities and colleges and special clinics would be other good resources for this type of service.

There are many other types of clinical specialists which a preschool might need to call upon. The "Resource Guide" in the Appendix lists several available types of clinical specialists and where they may be located. The specialists listed above were mentioned primarily because their services are frequently required by preschool programs enrolling special needs children. These specialists were also mentioned because they are often in a position to visit on-site at a preschool program and work directly with children and staff. Obviously, there are other specialists, such as medical doctors, who provide numerous services to preschool children. These specialists were not listed here simply because they are not typically available to provide service on-site at the program.

"WELL, KNOWING WHO TO ASK FOR HELP IS ONE THING. BUT HOW CAN WE GET THESE SPECIALISTS TO ACTUALLY HELP US - ESPECIALLY WHEN WE DON'T HAVE MUCH MONEY TO PAY THEM?"

The task can be easier than many think. It may be helpful to consider why more clinical specialists in the community do not work with preschools. Very frequently, the specialist does not even know that the preschool program exists in the same community. Often, no one has asked the specialist for help. Consequently, the specialist is not aware that the program needs help. Also, it is not uncommon for people to think that Head Start and other preschools have the money to retain the necessary resources - after all, this is a pre-school and don't "the schools" have their own specialists? Many people remember the Great Society days when preschools seemed to be the focus of abundant federal dollars. Sometimes, a specialist may not be aware of the wide variety of services which he/she could provide to a preschool program. Finally, the preschool program, itself, may not be aware that various resources exist in the community or surrounding area.

Frequently, a Head Start staff assumes things that do not encourage the greatest specialist assistance. A most common, and often incorrect, assumption is that the clinical specialist would not be willing to help because she/he is overworked or would require payment, etc. Sometimes the Head Start person seems to say, "What right do I have to ask this other person to help us for nothing?" as though to do so would be unethical. In some cases, it is expected that it is the specialist's professional responsibility to seek out the preschool and not the other way around. In a nutshell, these kinds of assumptions can inhibit a program from taking the initiative of seeking out specialists and asking them for help. To recruit the assistance from clinical specialists, a program amy wish to consider some of the following techniques which have been successful for other preschool programs.

"HOW TO CATCH A SPECIALIST"

1. Adopt a positive attitude. Assume that the specialist really would like to help for several reasons: he/she is convinced that his/her work would be a lot easier if youngsters with problems were seen earlier; she/he would like to do anything to help preschool programs which the specialist believes are very important; the agency employing the specialist is strongly encouraging its ciinicians to serve a greater number of preschoolers; or the specialist would like an opportunity to satisfy various government regulations which may require service to the preschool population.

2. If possible, approach the specialist in the Spring or Summer prior to the next school year. During the school year many specialists are already precommitted to an excessively large caseload - this is particularly true for specialists in the schools. When a specialist actually does seem unresponsive to requests for help, the most common reason is that fact that he/she is already "booked-up." By approaching the clinician in late Spring, he/she often has enough time to plan ahead for service to the preschool program. However, many specialists will still make an effort to find time in their schedules even if they are asked for help during the school year.

3. Inform the specialist of the specific needs and resources of the Head Start program. The specialist may not be aware that the Head Start program does, in fact, work with special needs children or that the program has limited financial resources (or that it even exists). If at all possible, provide the clinician with an idea of how many youngsters with certain kinds of difficulties were in the program last year. What, in fact, were the concerns and needs of the staff and the parents last year? Presently, what centers, how many youngsters, parents, and staff are in particular need of the specialist's services? Up to this point, what kinds of help has the program received in the specialist's field? A preschool could try several ways of introducing the program to the specialist. For example, the specialist might be invited to the preschool's "open house," to meet with the staff during a staff meeting, to participate as a guest in a particular activity of the parent organization, or to attend a staff pre-service or in-service activity. The specialist could also be place on the preschool's mailing list.

4. Suggest to the specialist that there is a wide range of services which he/she could provide for which the Head Start program is in need. The specialist may be thinking, "With my limited available time, I don't think there is much I can do which would be too effective." IMPORTANT!!! The question here is not simply, "What is the very most effective thing the specialist can do." Rather, the question should be, "What is the most effective thing a specialist can do with the available time and resources."

The role of the specialist has often been seen by that specialist and the recipient as limited to just a few functions. Many people are used to formal one-to-one sophisticated testing and one-to-one therapy. On the other hand, several psychologists, social workers, speech pathologists and others have stated a preference for roles like observation of children in the classroom followed by consultation with teachers and families. The fact is, it has never been "decided" what kind of service is most effective for mental health and other professionals to provide. It is recommended that the specialists and the preschool staff consider a greater variety of specialist roles. For example, could the specialist:

A. Directly observe children in the classroom and/or in the children's home?

B. Meet regularly with the teacher to discuss ways of working with individual children?

C. Meet with the teacher to help plan things like curriculum activities, uses of space and equipment, scheduling of activities for all the children and other types of overall classroom management techniques?

D. Provide the teacher with the same kinds of services as mentioned in B. and C. but mainly by phone or written communication?

E. Recommend books, learning packages, and other materials for the teacher?

F. Provide formal in-service training to groups of staff and/or parents?

G. Provide screening services for the children?

H. Provide more complete diagnostic testing of children? If so, where - in the center, in the children's homes, or at the specialist's location?

I. Provide direct service (e.g., teaching therapy, counseling) to individual children? If so, where - in the center, in the children's homes, or at the specialist's location?

J. Provide counseling to parents regarding how they might work with their children or on other matters?

K. Provide consultation at staffing meetings (that is, Comprehensive Developmental Team meetings)?

L. Provide assistance in identifying and recruiting other specialists?

By considering all of these possible roles it is more likely that some type of service can be obtained from a specialist even if that person has very little time to offer himself/herself. For instance, a specialist who is very busy might at least be willing to help identify and recruit other specialists who could spend more time with the program, or to conduct one or two in-service training sessions during the year. Even if only a small amount of service is obtained the program has made a contact with the specialist and this may help to obtain more service in the future.

The preschool staff may have at least a general idea of how many specialists are available and how much time each might devote to helping the program. Therefore, the staff might consider these questions:

"What is the most efficient way a specialist can help our program?"

"What are the alternatives to having all of the above roles filled by a specialist?"

Here are some examples of what may be the most efficient and effective use of a specialist's time:

Example 1 A psychologist and a speech pathologist are available to the preschool for two hours each week. The most efficient use of the specialist's time and effort may be in the roles of classroom observation, consultation with teachers, consultation with parents, consultation with the Comprehensive Developmental Team, in-service training for the staff and/or the parents, and possibly some diagnostic testing.

Example 2 A speech pathologist can come to a center for one hour each week. If she/he were asked to conduct full diagnostic assessments it is likely that all of her/his time would be taken to fulfill this one role. More services could be rendered if the speech pathologist spent some time observing the amount and quality of verbal output and comprehension of some children as well as consulting with teachers regarding overall programming for maximum language development and output.

Example 3 A social worker can come to a center for one to two hours every two weeks. Perhaps the staff could ask this specialist to spend half of her time performing such roles as classroom observation and consultation with teachers. The other half of her/his time might be spent consulting with the Comprehensive Developmental Team. The fewer on-site specialist services available the more important it may be for the specialist to meet regularly with the Comprehensive Developmental Team.

Example 4 It may be obvious that as the number of available specialists and their time is reduced, the staff must be more selective with respect to which services the specialist is asked to provide. So let us say that a classroom can receive the on-site

services of a specialist for only a couple of hours each month. The greatest service to the most children would result from asking the specialist to spend that time consulting to the Comprehensive Developmental Team. In this way, she/he could listen to the descriptions of a child, suggest additional observation of specific things by a member of the Comprehensive Developmental Team, suggest a resource for diagnostic assessment, offer suggestions for classroom management of the child, etc.

5. Consider the specialist's time limitations. Restrict the number of centers or classrooms the clinician is asked to help, as well as the frequency of visits requested. Again, the specialist may be thinking, "I'm willing to help out. But that sounds like more than I have time to handle." Also, some specialists are restricted to defined geographic boundaries. Examples are psychologists, speech pathologists, and other special education personnel employed by the public schools. The preschool staff should anticipate this. It is up to the staff to show the specialist how she/he can be of great help even with limited available time and boundary restrictions. Therefore, if the preschool program has more than one center or classroom try to limit the number that the specialist will be asked to serve. If the centers are large or far apart, the specialist may be asked to serve only one center. This can be a good selling point in that the specialist is being asked for a limited amount of time to serve a limited number of centers - as opposed to serving the entire porgram. For instance:

Example 1 The preschool program has three centers or classrooms. One center is large and the other two are small. If two psychologists are available, one psychologist might be asked to service the large center while the other is asked to serve the two smaller centers.

Example 2 The preschool program has four centers with twenty to twenty-five children in each. The centers are all far apart. Two are served by an educational cooperative, so the cooperative could be asked to serve these centers. The other two centers are in separate school districts. Each school district might be asked to provide specialist service to the preschool center in its geographic boundaries.

Example 3 The preschool program has two large centers only fifteen miles apart and one small center thirty-five miles from either of the large centers. The small center can be served by one speech pathologist, and she has two hours to give each center. If she went to each of the large centers every week, part of the two hours would be spent traveling between them. The speech pathologist might be asked to spend alternate weeks at each center, thereby getting a full two hours service at each classroom.

Example 4 The program has two centers which differ mostly in the fact that many more special needs children seem to be in one center. A specialist can visit once a week for two hours. The clinician could be asked to visit the center with more special needs children twice to every one visit at the other center.

6. Regardless of what kinds of services the specialist may offer, try to encourage services which are on-site (i.e., at the program location and in the classroom). For example, if the clinician has offered to counsel teachers, there could be many advantages to the clinician spending some time on-site, in the classroom. Obviously, the specialist could first hand appreciate the teacher's concerns. The specialist could respond to situations and problems with less delay. One of the greatest advantages is that the specialist often has a chance to notice other things beyond the immediate problem.

> When making his regular monthly visit to the preschool the school psychologist may have been asked to help the teacher with a child throwing temper tantrums. While watching this class, the observer may also notice a little girl sitting in the corner who, in the last two hours, has not once looked up from grooming her doll. She neither seems to ever leave the corner or interact with the other children. To the staff, this was just the way Jenny is - "She's just being Jenny." She was never a bother to anyone. When he stopped by the next week, the psychologist saw the same thing.

Sometimes when a child seems to be having problems, then the environment must be changed a bit (e.g., lighting, where the teacher and children sit during storytime, how and when the children are grouped, placement of obstacles and passageways, flexibility of toys and equipment, scheduling, etc.). Unless the specialist is on-site, it can be quite difficult to appreciate how an environment might need to be modified for an individual child. And by being on-site, it may be more likely that the specialist will eventually come to feel part of the whole program and, as a result, provide more services and advocate for the preschool within the community.

7. Try to pre-arrange a schedule of regular and on-going assistance from the specialist (as opposed to asking for help only when a particular major problem arises). If there is a regular schedule of on-going assistance, then the program staff does not have to make the "sticky" decision of when a problem is serious enough to warrant "bothering" the specialist. More importantly, the staff and specialist can then also attend to non-crisis situations - such as overall program improvement and curriculum planning, and dealing with smaller concerns before they get to be problems. A regular schedule can also give the specialist a better idea of exactly how much time is being requested.

8. Include the specialist in as many aspects of the preschool as possible. Sometimes the specialist is regarded by the preschool staff as someone "out there" who comes in only when the staff or kids have problems. Especially if there is no regular schedule of assistance, it may seem that the only contact is when the preschool calls the specialist to say, "We need you to help us." There are other ways to get the specialist to stick around the preschool. If the specialist comes to feel that she/he is a regular part of the program - that there is a personal investment in this preschool - then there may be the closest kind of specialist support which a preschool could experience. The same ways of introducing the preschool to the specialist could be used on an on-going basis to gradually help the specialist feel more a part of the program.

"WHAT PUBLIC FUNDED AGENCIES, EMPLOYING CLINICAL SPECIALISTS, ARE REQUIRED TO PROVIDE REDUCED-FEE SERVICES TO POPULATIONS LIKE HEAD START?"

As a general rule, a government clinical facility (e.g., city, county, state, or federally funded hospital, clinic, or institution) must provide its type of services to all eligible citizens. Many such facilities are ordered to meet special requirements that they must serve special populations such as preschoolers, low-income people, etc. Within a governmental region such as a country there often are specific agencies required by law to provide or ensure almost all types of human services. The particular agencies charged with these responsivilities vary from state to state. The responsibility for ensuring that such services are provided usually rests with the federal (Washington, D. C., or federal regional offices), state (state capitol), or county (county seat; county board of commissioners) department of health or education or welfare. It is to the advantage of the preschool staff to know:

A. what are the public responsibilities to serve the special needs children?

B. which agencies at the state and local levels are responsible for carrying out the public responsibilities?

C. how does a parent or Comprehensive Developmental Team initially obtain these services, or petition these services from an uncooperative source?

General answers to these questions might be obtained from:

1. a Director of Special Education in the local school district;

2. a State Legislator who is on a health, education and/or welfare subcommittee;

3. the State Department of Education, Special Education Section;

4. the Council for Exceptional Children (1920 Association Drive, Reston Va., 22091);

5. the State Association for the Education of Young Children;

6. the State Association for Retarded Citizens;

7. the State Association for Children with Learning Disabilities;

8. Closer Look, National Special Education Information Center, Box 1492, Washington, D. C.

It has been the experience of some preschool programs in some states that most of the program's special needs children are eligible for specialist services from the public school system. It is necessary that a Comprehensive Developmental Team be able to answer these questions:

1) what are the school district's responsibilities to serve special needs children?

2) which agencies at the state and local levels, other than school districts, are responsible for carrying out the state responsibility?

3) how does a parent or Comprehensive Developmental Team obtain these services from an uncooperative source?

Answers to these questions might be obtained from:

a) the local school district or other responsible agency

b) the special education section of the state department of education

c) the Council for Exceptional Children, 1920 Association Drive, Reston, Virginia, 22091

d) the State Association for the Education of Young Children

e) the State Association for Retarded Citizens

f) the State Association for Children with Learning Disabilities

It would be helpful to a Comprehensive Developmental Team, all program staff, and parents to compile a brief written explanation of school district responsibility to serve special needs preschool children. Finally, to locate clinical specialists who can provide a preschool program with regular, on-going, and on-site services, the following agencies are more often utilized:

- community mental health centers
- city and county public health nursing services
- city and county welfare
- city and county family and social services
- the public schools - in many states, local public school systems are the most available and widely utilized resource for the preschool which enrolls special needs children.

IN-SERVICE TRAINING

Regardless of their availability for regular, on-site services, several specialists are willing to provide your staff with in-service training -- BUT ONLY IF YOU REQUEST IN-SERVICE TRAINING.

Planning your training

As you plan your agency in-service training, remember:

A. Even if a subject has been discussed before, it can be covered again or expanded.

B. There are several skill areas with which your staff must be familiar.

C. There are several specialists who might be used for in-service training during the year.

D. The specialists and their areas should be presented in a logical sequence.

E. It should be obvious to the participants how each subject relates to the others.

Figures 1 and 2 are some examples of areas on which in-service training might be conducted, as well as different ways of organizing this training.

The in-service training should:

A. Cover a topic which is limited in volume.

B. Directly speak to the specific needs of the participants.

C. Deal with needs which can be constructively affected by the technique of presenting information.

D. In some way, be followed by practical on-the-job application.

Contacting the specialist

When asking a specialist to conduct in-service training, one of the first questions the specialist may ask is, "Exactly what do you want me to do?" Or, she may not even ask for specifics, which could result in poorly planned or irrelevant training. In either case, you might suggest the following:

A. Topics important to the teachers, parents, and/or staff, such as: (not necessarily single topics for a workshop)

1. how can the teacher (parent) identify a problem (e.g., screening, observation skills, checklists, etc.)

2. how does the teacher (parent) find professional help

3. what can the teacher (parent) ask from specialists (e.g., screening, diagnosis, treatment/therapy, consulting, staffing, on-site visits vs. indirect services, etc.)

4. what can the teacher (parent) do for the child in the classroom (home) (e.g., task analysis, experiential stimulation, behavior modification, etc.)

5. how does the teacher (parent) evaluate services received

6. how can/do parents and teachers coordinate their efforts

7. how does the child with special problems affect the other children and vice versa

8. what are some of the possible causes of such a problem

9. what are some current "treatment" approaches we either read about or do not hear about

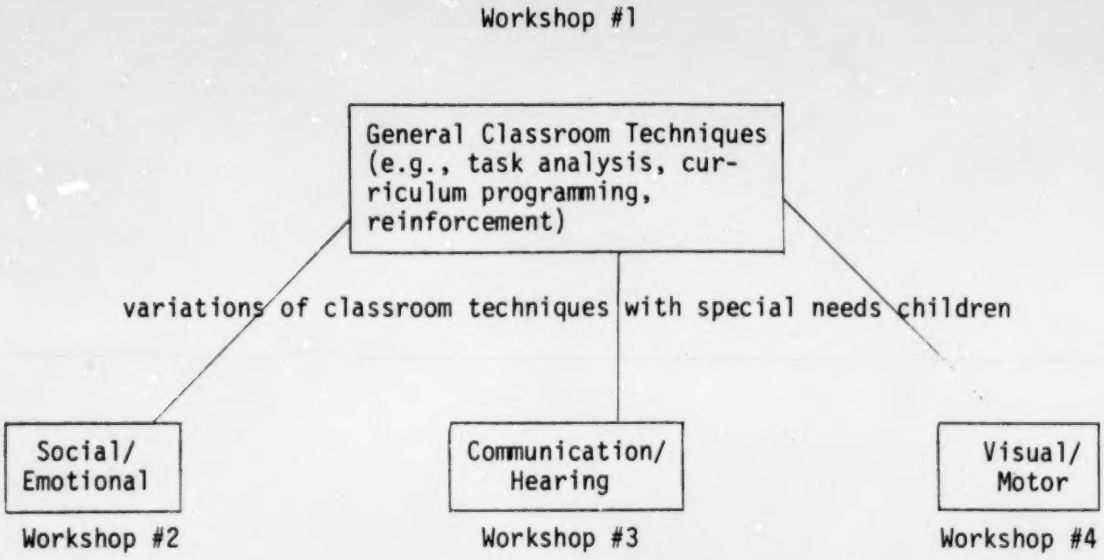
B. Number of participants attending

C. Background of participants (formal education and work experience)

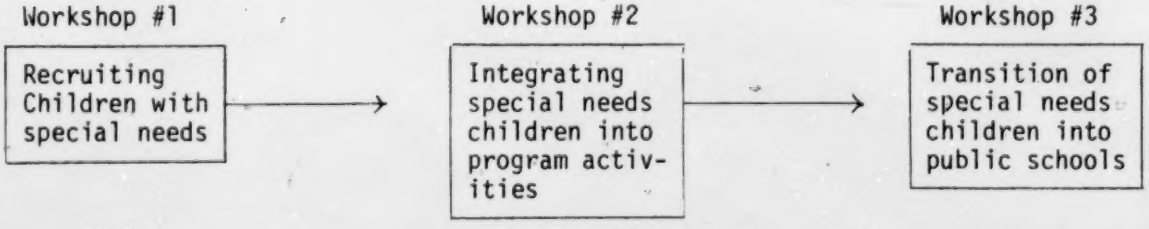
D. Previous in-service training related to this subject

E. Time available (2 or 3 hours is probably best for half-day sessions)

F. In-service activities desirable (It is suggested that the best situation would include small group discussions, films, role playing, guests who are parents of children with such a special need, visual aids, and handouts. Lecture presentations have usually been most effective when limited to 45 minutes, followed by practical application.)



(Figure 1)


Workshop #1
Recruiting Children with special needs
Workshop #2
Integrating special needs children into program activities
Workshop #3
Transition of special needs children into public schools

(Figure 2)

Each figure shows the in-service training of different subjects. But, in any case, the subjects/programs are organized in a specific scheme. Two different schemes are pictures. Figure 1 assumes that the first workshop is the foundation of later subjects (workshops) which are variations on that theme of the first workshop. But Figure 2 presents subjects in the same order as those skills will have to be performed in real life by the teachers, staff, and parents. Of course, other subjects can be presented and they can be organized in many different schemes.

RESOURCE GUIDE

Areas to be covered	Speech & Language	Hearing	Vision	Motor	Social & Emotional
Appropriate Specialists - (those in parentheses might be able to do screening)	Speech pathologist	Audiologist	Ophthalmologist	Pediatrician MD	Child Psychologist
	(Child psychologist)	(Speech pathologist)	Optometrist	Physical Therapist	Psychiatrist, MD
	(Special education teacher)	(Public health nurse)	(Public health nurse)	Neurologist, MD	(Special Education Teacher)
	(Teacher of the deaf)	(Ear, nose & throat MD)	(Pediatrician, MD)	(Child psychologist)	(Speech pathologist)
	(Public health nurse)				(Public Health nurse)
		(Pediatrician MD)	(General practitioner, MD)	(Speech pathologist)	
				(Special education teacher)	
				(General practitioner, MD)	
				(Public Health nurse)	

Agencies	Public Schools	Crippled Childrens Services	Mental Health Center	Vision & Hearing Screening	Public Health Nursing Serv.	Local Agencies & Specialists
Specialists in Agencies	Child Psychologist	Child psychologist	Child Psychologist	Vision Specialists	Public health nurse	College training programs; medicine, special education, dentistry, speech pathology & audiology, child psychology
	Speech Pathologist	Speech Pathologist	Social Worker	Hearing Specialists		
	Special Education Teacher	Pediatrician	Public health nurse			County & city hospitals; pediatrics, otolaryngology, neurology, mental health, physical medicine & rehabilitation
	Public health nurse (school)	Public health nurse	Psychiatrist			
	Social Worker	Special education Specialist Surgeons Nutritionist Cenetisist Cardiologist Orthopedist	Medical doctor			Easter Seals-(child psychologist, psychiatrist, audiologist, occupational therapist, public health nurse)
		Dentists Optometrist Social worker	Mental retardation consultant			Society for Crippled Children & Adults-(same as Easter Seals)
		Otolaryngologist, audiologist	Maybe: Speech pathologist, audiologist			Special community clinics-(same as Easter Seals)
Services Provided	Screening Diagnosis Treatment	Screening, diagnosis Referral for treatment	Screening, diagnosis, referral for treatment	Screening In-service training	Screening, In-service training	Screening Diagnosis Treatment
	In-service training On-site consultation	In-service training On-site consultation	In-service training On-site consultation			In-service training On-site consultation

GLOSSARY OF SPECIALISTS

Audiologist - Conducts screening and diagnosis of hearing problems (not a medical diagnosis of the ear), evaluates hearing aid fitting, may conduct therapy of language development and hearing aid use.

Cardiologist - A medical doctor who conducts diagnosis and treatment/management of disorders related to the heart.

Child Psychologist - a non-M.D. specialist with special skills and understanding of the behavioral, developmental, and emotional problems of a child.

General Practitioner - A medical doctor with wide, general skills in the treatment and care of health problems.

Neurologist - A medical doctor who screens, diagnoses, and treats disorders of the nervous system such as paralysis, reflex coordination, perceptual dysfunctions, etc.

Nutritionist - A professional who has special training and experience in planning appropriate diets.

Ophthalmologist - A medical doctor who conducts screening diagnosos and treatment/care of disorders related to visual acuity.

SERC-Special Education Regional Consultant - A special education professional, employed by and reporting to the State Department of Education, Special Education Section. Each SERC is responsible for assisting special education directors and programs of public schools within the respective region.

Optometrist - Therapist skilled in the assessment of visual acuity and adaptation of corrective lenses, and in the assessment/management of visual perception and related difficultues.

Orthopedist - A medical doctor who diagnoses and treats/manages disorders related to the bone and skeleton.

Otologist - (ENT) A medical doctor who diagnoses and treats/manages physical disorders relating to the ear, nose, and throat.

Pediatrician - A medical doctor skilled in the diagnosis and treatment of childhood diseases, and in the health care of the child.

Psychologist - A non-M.D., trained in the understanding of human behavior and emotional development; conducts screening, diagnosis, and therapy through use of behavior management principles.

Psychiatrist - A medical doctor who conducts diagnosis and treatment, medication, etc. of psychological and behavioral problems.

Public Health Nurse - A registered nurse who surveys, screens, and manages family and community health care.

Social Worker - A professional with special training and experience in helping people interact with their society as well as with family relations, employment, finance, specialist referral, etc.

Special Education Teacher - A teacher with special training and experience in the education of children with special educational needs.

Speech Pathologist - A professional who conducts screening, diagnosis, and treatment of people who have communication disorders related to voice, language, articulation, motor skills, and hearing.

Teacher of the Deaf - Teacher with special skills in the academic education of the person with hearing loss.

The following suggestions are offered to staff who are meeting for the first time with specialists to request services. It is presumed that prior planning has been completed regarding the specific needs the Head Start agency has. This will help to answer most questions the resource specialist might have.

The following suggestions are made to ease any anxiety the staff may feel in soliciting such help.

The initial functions listed thus far have all been performed in preparation for this function -- meeting with the specialist face-to-face. Your prior preparations should stand you in good stead to answer most questions a resource specialist might have. Suggestions for the the face-to-face meeting:

- Introduce yourselves and your positions with Head Start
- Explain the reasons for calling the meeting, e.g., you want to have that specialist involved in the early stages of preparation for his type of service to Head Start.
- Explain the congressional mandate that ten percent of the children in Head Start must be handicapped.
- Describe the other things that are happening in Head Start, e.g. performance standards, career development, etc. Give the specialist a copy of the performance standards and a sheet outlining the administrative structure of your program -- the specialist needs to know to whom he is responsible, "should he decide to accept this assignment."
- Explain your needs:

    1. screening of all children
    2. assessment/programming/monitoring special needs children
    3. integration of special needs childre into the program
    4. transition of special needs children from Head Start to schools
    5. involvement of parents in the team process

- Explore the possible roles that the specialist could assume to help meet the objectives:

    1. refer to the roles you have deemed desirable for the specialist
    2. refer to number of centers you wish the specialist to serve
    3. refer to requested frequency of visits from the specialist

- Agree upon roles which specialist will assume
- Make an agreement with the specialist:

    1. a gentleman's agreement outlining the role of the specialist and the role of Head Start relating to that specialist.

        A gentleman's agreement is merely a verbal agreement that the specialist will provide certain services.

2. a written agreement outlining the exact role of the specialist and Head Start. This type of agreement is a written statement that the specialist and/or his agency agrees to provide particular services to Head Start. And it should outline the ways in which Head Start will cooperate with the specialist.

   Many specialists prefer some type of written agreement to a verbal agreement. His/her roles are stated in print for easy recall. This written statement of roles can be more easily interpreted to all Head Start staff. The specialist's employer may require a written agreement as evidence that a service agreement was made with Head Start.

   A written agreement does not need to remain the same throughout a program year. If the specialist and Head Start agree on any changes, they should be able to amend the written agreement at any time.

3. a written fee-for-service contract outlining the exact roles. This type of contract should be executed if Head Start is paying a specialist or agency for services. It is a legal safeguard for both parties. You may want to have a legal advisor examine the contract prior to making such a contract final. A statement should be included which outlines a procedure to amend the contract.

   Note: Head Start youngsters are entitled to several public services which are to be rendered without special payment. Therefore only engage fee-type services as a last resort.

Regardless of the type of agreement which the specialist and Head Start make, it is extremely important that roles be defined and frequency of services be specified.

a. The specialist should know what his responsibilities are to Head Start, e.g. observation, full assessment, parent conferences and training, teacher consultation, etc.

b. All Head Start staff need to be made aware of what the specialist will do.

c. Head Start should know what responsibiliteis it has to the specialist, e.g. providing developmental test information, arranging family conferences with the specialist, arranging in-service meetings, etc.

REFERRAL GUIDE

The following sequence suggests appropriate information to give to the specialist to whom you refer a child.

1. Your name _____
2. Your position _____
3. Your place of employment _____
4. Your phone number _____
5. Child's name _____
6. Child's age in years and months _____
7. Child's sex _____
8. The child does what? _____
9. How often each day? week? _____
10. Where does child do this? _____
11. When who is present? _____
12. What happens after (consequences) the child does this? _____
13. Similar behavior within family or friends? _____
14. Child's physical appearance? _____
15. Child's general condition of health? _____
16. When is this present? _____
17. Is this constant or off and on? _____
18. Similar condition among family or friends? _____
19. Who is child's doctor, and/or dentist? _____
20. When last pertinent examination by specialist? _____
21. Role of specialist desired? _____
22. Parents present? _____
23. Number of siblings? _____ Ages of siblings? _____
24. Child's order of birth? _____
25. Parents aware of situation? _____
26. Parents' reaction? _____

HOW A CDT IN REGION III UTILIZED COMMUNITY RESOURCES

Reed Booth, director of the Indiana County Head Start, Inc., indicates in this article how their Comprehensive Developmental Team increased the utilization of resource specialists and agencies. Indiana County Head Start, Inc. was one of the original eight pilot CDT's established in Region III during the Winter of 1976. During the year that followed, the program used the following resource specialists and local agencies in their attempt to provide better services to handicapped children.

During program year 1976-1977, Indiana County Head Start, Inc. developed a cooperative service agreement with the Intermediate Unit. The Intermediate Unit includes the diagnostic, evaluation and special education services available through the State Department of Education. A pre-school teacher from the Intermediate Unit is now assigned to work with the Head Start program once a week. She functions as a permanent member of the CDT team. Her services are provided at no cost to the Head Start program. The Intermediate Unit also provides psychological testing at no cost to the Head Start program.

Several of the Head Start children receive speech therapy on a regular basis through the Indiana University of Pennsylvania.

The Open Door Crisis Center, a counseling service, works with one family. The two children from this family have serious emotional problems that appear to be a result of the home situation. The Open Door is working with this total family group on a regular basis.

The Indiana County Guidance Center, a mental health/mental retardation unit, works closely with the Head Start teaching staff. They observe children, give feedback to teachers, and sometimes attend CDT meetings.

In some cases, the local school districts have been extremely helpful in providing the Head Start staff information, support and services.

The Indiana County Head Start, Inc. is now one agency in an interagency consortium of pre-school handicapped service providers for Indiana and Armstrong counties. Other members include the Intermediate Unit, Easter Seal and United Cerebral Palsy. As a member of the consortium the Head Start program is eligible to call on personnel and services from the other agencies at reduced or no cost.

The Head Start program has also begun use of college interns and volunteers to follow through on specific learning experiences for children staffed at the CDT meetings.

The above list indicates an increased utilization of local resources by one Head Start program. The director and staff feel that implementing the CDT process was most instrumental in accessing the services of these local agencies and specialists. Although the Indiana County Head Start, Inc. feels encouraged by this progress, the staff continue to seek ways to better serve their special needs children.

EXECUTIVE SUMMARY:

SCREENING DIAGNOSIS AND ASSESSMENT OF

HANDICAPPED CHILDREN

IN HEAD START

JUNE 30, 1976

THIS REPORT WAS PREPARED FOR:

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF HUMAN DEVELOPMENT,
OFFICE OF CHILD DEVELOPMENT
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EXECUTIVE SUMMARY

This report represents the findings and recommendations from an information gathering effort on the screening, diagnosis, and assessment of handicapped children in the Head Start program. A field study and resultant draft reports were completed in the fall and winter of 1975 for the Office of Child Development (OCD) by the American Academy of Pediatrics. The incorporation of suggestions and recommendations from reviewers of the draft report was completed by Westinghouse Health Systems in the spring of 1976.

The Head Start program has been mandated by law to provide a comprehensive developmental program for pre-school handicapped children. The legal mandate has further stipulated that the number of handicapped children should represent at least 10 percent of the total number of children served by the Head Start program in each state. Appropriate screening, diagnosis, and assessment is one of the areas of the Head Start program for handicapped children required by the Office of Child Development to meet its legal mandate.

The accuracy of screening, diagnostic and assessment services at the local level had been questioned in two reports and in Congressional committee hearings. The possibility of misdiagnosis and therefore provision of inappropriate services were two areas of concern raised in reports and hearings. The high percentage of children reported as speech impaired and health impaired was also identified as a potential problem area.

The Office of Child Development has relied on training and technical assistance to improve the delivery of various services to Head Start children. The purpose of this report was, therefore, to gather information to be used in planning those training and technical assistance activities to focus specifically on the screening, diagnostic, and assessment services for handicapped children. The primary audience to whom the report is directed are training and technical assistance providers, policy planners, and program planners at national, regional, state and local levels.

The purpose of the field study and report was to identify and analyze in-depth the barriers to effective screening, diagnosis, and assessment of children with handicaps in order to improve future training and technical assistance planning and services. It was not to confirm or deny the previously cited concerns about service provision in a representative sample of Head Start programs. The programs participating in the information gathering effort were specifically selected because they had previously reported incidences of handicapping conditions which seemed either significantly higher or lower than Head Start national norms as reported to the Congress. Although the sampling mechanism does not permit generalization of these findings and recommendations to other programs at this time, it was assumed that several of the problems identified could, to some degree, be characteristic of many Head Start programs. The applicability of these findings and recommendations for other Head Start programs will be done through regional training and technical assistance mechanisms.

The study began by reviewing and analyzing existing information, such as pertinent legislation, OCD regulations, policies and guidance materials,

a National Survey questionnaire results and its Report, and a Government Accounting Office (GAO) Report. On the basis of the analysis, three major areas were identified for study in the information gathering effort:

I. IDENTIFICATION AND UTILIZATION OF DIAGNOSTIC RESOURCES
II. DEVELOPMENT OF A TEAM APPROACH TO THE DIAGNOSTIC EVALUATION OF HANDICAPPED CHILDREN
III. PARENT INVOLVEMENT AND PARTICIPATION WITH DIAGNOSTIC RESOURCES AND/OR TEACHERS.

The report focuses, therefore, on these areas since they have presented implementation problems for OCD policies. Each area was looked at in terms of existing information and information generated by site visits to a non-random smaple of thirty-five programs. These information gathering activities resulted in three categories of recommendations:

A) Training and technical assistance to local programs
B) Office of Child Development policy and practices
C) Future research, development, and demonstration.

A case study methodology was utilized to gather new information. A questionnaire was developed and used to obtain information on 106 handicapped children in 35 Head Start programs throughout the country. Each case study involved interviews and completion of a questionnaire with Head Start administrative staff, diagnostic provider, family member(s), and Head Start teacher, all of whom were involved with the same handicapped child. The 100 interviewers were specially trained interdisciplinary consultants representing the fields of: Administration, Architecture, Education, Law, Nursing, Nutrition, Occupational Therapy, Pediatrics, Physical Therapy, Psychiatry, Psychology, Religion, Social Work, and Speech and Hearing. The results and recommendations from the case studies were assembled into a draft report which was then sent for review and comment to members of an interdisciplinary advisory committee, local participating programs, regional offices of the Office of Child Development, and national professional and parent organizations concerned with handicapped children. Comments from respondents were then incorporated into the final report.

I. IDENTIFICATION AND UTILIZATION OF DIAGNOSTIC RESOURCES

Most of the report's data concerns the area of resource identification and utilization. OCD policy and guidance directs Head Start programs to insure professional diagnoses by persons trained in assessing children with specific handicaps to confirm the initial identification of a handicapped child. Previous information had identified the professionals used for diagnosis as:

- private physicians, psychiatrists and other medical professionals 55%
- other qualified professionals, including psychologists, speech pathologists, etc. 27%
- professional, qualified Head Start staff 17%

The Head Start staff was not identified in terms of professional disciplines.

Results from the sampled programs showed that Head Start programs utilized two major groups of diagnosticians. About 25% of the children were reported as diagnosed by teams which means that more than one professional was involved in the diagnostic process. The majority of these professionals were employed by public or voluntary agencies and were located in urban areas. The second group, representing about 75% of the diagnosticians, were not members of a diagnostic team. They constituted most of the diagnosticians available in rural areas of which over 60% were private practitioners, predominantly physicians, psychologists and speech pathologists.

OCD policy and guidance suggest that the diagnostic providers could be best utilized in prescribed ways which include:

- Diagnostician uses the legislated definitions and the diagnostic criteria to report a child as handicapped.
- Diagnostician provides information in such a way that it can readily be reported in the annual survey.
- Diagnostician undertakes functional assessment of child.
- Diagnostician provides recommendations, based on the functional assessment, that allow parents, teachers, and others to best work with the child.
- Diagnostician guards against misdiagnosing a child (mislabeling) as handicapped by: 1) recognizing ethnic and cultural factors and normal developmental stages; and 2) utilizing appropriate assessment techniques and procedures.

In other words, diagnostic resources when effectively utilized should provide Head Start programs with:

1) A Categorical Diagnosis - a report assigning the child to one or more of the ten categories of handicapping conditions using the specific diagnostic criteria developed for this purpose in Head Start.

2) A Functional Diagnosis - a report describing an individual child's functioning and areas of need; e.g. what a child can do and areas to be improved.

3) Recommendations for Teachers and Parents - a report, whenever feasible, should contain recommendations for teachers and parents which would be appropriate to the child's developmental level and needs. Recommendations in this form are more readily utilized by Head Start programs in developing an individualized plan for the child.

These activities should reflect an awareness of cultural, ethnic, and developmental considerations and accordingly use appropriate instruments and assessment procedures.

Previously collected information indicated that a professional categorical diagnosis was documented in about 75% of the reviewed Head Start records. A professional functional diagnosis was found in only about 25% of the records. One concern raised from the record review was that the lack of documentation might represent misdiagnosis either as to the category or the degree of functional impairment. As a result, the individual child or family might be exposed to unjustified labeling or stigmatization.

The results from the sample studied showed a documentation level of about 75% for the categorical diagnosis and about 65% for the functional diagnosis. The lack of documentation for a categorical diagnosis did not necessarily represent a misdiagnosis, but rather indicated the absence of a written categorical diagnosis from the diagnostic provider. There were no instances found where the Head Start program considered a child handicapped and the diagnostic provider considered the child non-handicapped. The major reason for undocumented records was the diagnostic provider's unawareness of Head Start's need for such information. Almost all of the diagnostic providers interviewed had never seen the legislated categories or diagnostic criteria. Once presented with the information, over 75% of them reported their willingness to use the desired reporting categories.

The nearly 25% who reported that they would not report in the legislated categories gave philosophical reasons for their refusals. Those who refused were mainly concerned with the categories of mental retardation, serious emotional disturbance, and the health or developmental impairment subgroup related to hyperactive children. The most frequent reason given was the conviction that most pre-school children cannot with certainty -- and therefore should not -- be placed in one of the three categories. Most who shared these feelings also cited the considerable professional and lay literature which discussed the dangers of labeling, and their concerns about the possibility of malpractice suits.

Diagnostician concern about mental retardation, serious emotional disturbance and health or developmental impairment also contributed to the high incidence of speech impairment reported by some programs. Many mentally retarded and emotionally disturbed pre-school children have concomitant communication problems. Some diagnostic providers and Head Start staff reported a tendency to assign a child to the least potentially stigmatizing category for reporting purposes.

The lack of documentation of functional diagnoses seemed mainly attributable to the diagnostic provider's lack of awareness or understanding of the need to report in functional terms rather than to misdiagnosis. Many diagnostic providers expressed their willingness to provide this type of diagnosis in the future. Other providers, particularly physicians in private practice, did not see functional diagnoses as within their professional responsibility or interest. Some expressed the belief that Head Start staff were in a better position to provide functional diagnoses. A similar point of view was also expressed by diagnostic providers in providing specific recommendations for the individualized care of the child on a day-to-day basis by the teacher and/or parent. A lack of

agreement and standardization on the content of individualized plans was noted. Over 40% of the teachers had no written individualized plans. As a result no documentation of the use of diagnostic recommendations was available.

An attempt was made to address the problem of mislabeling by asking diagnostic providers what special considerations, techniques, and/or testing they used if a child was from a minority group. About 60% of the children in the sample, it was found, had been diagnosed from tests designed specifically for a particular minority group, although some of the tests were administered in the child's native language. A number of speech and language diagnosticians reported that they had to evaluate test results in the light of their knowledge of local dialect patterns found in economically disadvantaged populations. A concensus among consultants and reviewers was that additional information was needed in this area.

Highlights of the recommendations derived from the collected information are:

A. DIAGNOSTICIAN - HEAD START COMMUNICATION

Primary emphasis should be placed on raising the level of awareness and communication between diagnostic providers and Head Start programs.

1. Head Start programs need to be made aware of the necessity of their obtaining written documentation for both categorical and functional diagnoses.

2. At the beginning of the program year, Head Start programs should make their needs known to diagnostic providers. This is best accomplished by individual or group face-to-face meetings. The agenda for the meeting should include, but not be limited to:

   (a) Presentation and discussion of Diagnostic Criteria for Reporting Handicapped Children in Head Start;

   (b) Reporting procedures, indluding use of simplified reporting forms;

   (c) Procedures for safeguarding against labeling and stigmatization, minority group testing, and preparation of individualized plans.

3. Head Start programs need to be aware of which services diagnostic providers will provide. It must be recognized that many diagnostic providers are not trained to provide all three: a categorical diagnosis, a functional diagnosis and recommendations for teachers and parents.

4. Head Start programs should have a provider service profile for each diagnostician. An adaptation of the questionnaire used in the information gathering effort could be used to obtain this

information which would allow programs to identify service gaps. In many cases Head Start professional staff could fill these gaps after receiving minimum training and technical assistance.

B. LABELING AND STIGMATIZATION

Two approaches are recommended for addressing the problem of labeling and stigmatization:

1. Develop a dual record system. The categorical diagnosis would remain at a central location and the functional diagnosis would be entered in the child's record at the Head Start center.

2. Begin a training and technical assistance program to destigmatize the categories of emotional disturbance and mental retardation. This could best be accomplished as part of a continuing community education program in conjunction with national parent organizations or other groups.

C. MINORITY TESTING

Head Start's concern with the testing of minority group children is shared by the Office of Education. The latter's new legal mandate is to assure "tests and evaluation materials are not racially or culturally discriminatory" (PL94-142). It is recommended that the Office of Child Development and the Office of Education jointly explore this area of mutual concern at both the federal and local levels.

D. INDIVIDUALIZED PLANS

Office of Child Development guidance in the development of individualized plans is needed before diagnostic providers can be used most effectively in assisting Head Start staff to develop plans. It is difficult for diagnostic resources to provide information in a format which assists plan development without criteria, definitions, or guidelines of an acceptable plan.

II DEVELOPMENT OF A TEAM APPROACH TO THE DIAGNOSTIC EVALUATION OF HANDICAPPED CHILDREN

The second area in which information was gathered was on the implementation status of OCD policy and guidance encouraging the use of multidisciplinary diagnostic teams. There is currently no OCD definition of a multidisciplinary diagnostic team. For this project's purposes a definition was developed which defined a multidisciplinary team as one consisting of three or more professionals of different disciplines or specialties.

No data was available on the use of teams by Head Start programs. In the sample studied, on-third of the children had been diagnosed by multidisciplinary teams, one-sixth of which were composed entirely of medical

specialists. Only one team would diagnose all ten categories of handicapping conditions. All Head Start programs in the sample utilized multiple diagnostic providers including teams and individuals.

One trend noted was for Head Start programs to form or use existing teams consisting of Head Start Program component directors. These teams were involved mainly with intake, translating professional reports, and developing individualized plans. There was no Head Start team that considered itself to have a diagnostic function. Another trend found was the utilization of either a Head Start staff person as a member of a community diagnostic team for a specific child or of a professional to join the Head Start staff team around a specific child. 40% of the individual practitioners reported that they had been involved in similar types of ad hoc teams in their community in the past.

Three types of teams were defined by the study findings:

1) Internal Teams - teams consisting of members of Head Start staffs from three or more components.

2) External Teams - teams consisting of three or more members from:

   a) different professional disciplines (interdisciplinary)

   b) different specialists within a professional discipline (intradisciplinary)

3) Combined Teams - teams consisting of an internal team member as a consultant member to an external team or vice versa.

Highlights of the recommendaitons derived from the collected information in this area are:

A. DEVELOPMENT OF INTERNAL TEAM CAPABILITY

Primary emphasis should be placed on "mainstreaming" the handicapped program into the responsibilities of all Head Start components, with the development of an interdiscipinary team capability within Head Start programs which would supplement existing community resources for diagnosis and ongoing assesement.

1. Head Start programs need to maximize the integration of the components of administration, education, health, parent involvement, and social services.

2. The handicapped program needs to be included as part of the overall effort for component integration with the formation of an internal team of component directors.

3. One of the functions of the internal team would be an ongoing assessment and review of each handicapped child which would provide ongoing diagnostic information.

B. EXPANSION OF EXTERNAL TEAM CAPABILITY

The difference between interdisciplinary and intradisciplinary teams needs to be recognized. The functions of intradisciplinary teams need to be supplemented for purposes of meeting the Head Start requirement to provide a comprehensive developmental service. Head Start programs need assistance in defining the diagnostic and assessment needs for each child and in determining which areas require supplementary information for existing diagnostic and assessment reports.

C. DEVELOPMENT OF A COMBINED TEAM CAPABILITY

The recommendations for internal and external team capability can most readily be attained by staff interchange between Head Start programs and diagnostic providers to form combined teams. Head Start programs need assistance in integrating their staff and consultants from other teams and vice versa.

III. PARENT INVOLVEMENT AND PARTICIPATION WITH DIAGNOSTIC RESOURCES AND/OR TEACHERS

The third area in which information was gathered was on the status of implementation of OCD policies and guidance requiring parent involvement. Policies and guidance are not restricted to the parents of handicapped children, but are applicable to all parents.

Existing information from the Third Annual Report indicated that services had been provided to about one-third of the parents of handicapped children in Head Start. The information was not in a form to permit determination of the level of parent participation or the extent of their involvement in screening, diagnostic or assessment services. The GAO Report indicated that parent involvement was a problem area in most Head Start programs when evaluated in terms of classroom participation, attendance at meetings, and teacher home visits. There was no specific information pertaining to the extent of involvement for parents of handicapped children.

Information was gathered on parent participation by developing a six-step model of the diagnostic process. Direct parent involvement at each step, as well as secondary involvement through teacher participation, was ascertained. The information was obtained from diagnostic providers, parents and teachers, and their responses were compared for extent of agreement. The findings showed a clustering of parental involvement into three groups -- high, intermediate and low levels of participation -- based upon the active role taken in each step.

High level participation accounted for about one-third of the sampled parents. The majority of the parents had a low level of involvement, and it was the consensus of the diagnostic providers that a large number of the families could not meaningfully participate in the diagnostic and assessment process. The families were left to require a great deal of preparation and motivational stimulation which the diagnostic provider had neither the time, staff, nor funding to provide.

Less than one-sixth of the teachers reported active involvement in the diagnostic process. As a consequence, teachers did not feel they had sufficient information or skills for a secondary involvement in assisting parent participation in the diagnostic and assessment process. A majority of parents perceived the Head Start teacher as having a role in interpreting diagnostic and assessment findings and having complete responsibility for their child's program.

Highlights of recommendations derived from the collected information in this area are:

A. PARENT PARTICIPATION

Primary emphasis should be placed on the recognition that Head Start parents are at various levels in their abilities and willingness to actively participate in the planning and care of their children.

1. Head Start programs need to have alternative parent involvement programs related to parental ability and willingness to participate.

2. Those parents of handicapped children who demonstrate ability and initiative for active participation should receive training and technical assistance for meaningful participation with both internal and external teams.

3. Following training, technical assistance, and practicum experience, the parents who are able and interested in parent participation should be utilized in assisting other parents to take part in the program.

B. TEACHER PARTICIPATION

Teacher participation in external teams does not appear to be a meaningful strategy for most programs. A more realistic approach would be to involve teachers as members of internal teams whose function is to consider the program of each handicapped child. The individualized plan with parent participation should be the focus around which diagnostic and assessment information is utilized and integrated.

Information was also collected on the priorities of diagnostic providers, teachers, and parents for future training and technical assistance to provide direction for implementing the recommendations in the three major areas. The major findings were:

1. The most frequent recommendation of all groups was that no additional training and technical assistance was needed in the areas of screening, diagnosis, and assessment. One reason given to explain this was satisfaction with current services. Another was their feeling that the area was of low priority, considering the limited time available for participation in training and/or technical assistance activities. Many of those who gave this reason felt they had greater needs in other areas.

2. Technical assistance related to the management of specific children was expreseed by a majority as being preferred to group training activities. These latter training activities were described as usually being too broad and too general to be able to be translated into a concrete plan for a particular child.

3. Training or technical assistance in administrative areas, such as records or reports, was often perceived as a necessary evil -- unrelated to helping the child. Required information was most often viewed as a distracting and time consuming endeavor which was collected for someone else's use. Many expressed the feeling that this attitude was widely shared and was, therefore, a significant barrier to any training and technical assistance activities involving records or reports.

Highlights of the recommendations derived from the collected information are:

A. NEED PRIORITIES

Recognition needs to be given by training and technical assistance planners and providers that their need priorities may not be shared by the recipients of such activities. The effectiveness of training and technical assistance activities can be increased by allowing recipients to participate in self assessments of their own needs. An instrument such as the Self Assessment/Validation Instrument (SAVI) with items in the area of screening, diagnosis, and assessment would be helpful in meeting this need.

B. TRAINING AND TECHNICAL ASSISTANCE METHODOLOGIES

Training and technical assistance methodologies involving records and reports should:

1. First identify and deal with probable attitudinal barriers.

2. Use a case study approach or Head Start staff, who have successfully used records or reports, to illustrate how records and reports are relevant to individual children, families or programs.